TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
CONSULTANTS IN PAIN MEDICINE PA

Respondent Name
TRAVELERS INDEMNITY CO OF CT

MFDR Tracking Number
M4-18-0060-01

Carrier's Austin Representative
Box Number 05

MFDR Date Received
SEPTEMBER 6, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "J7999-KD was underpaid. **Please note this is compound drugs for a pump refill.**

Morphine (.050x440) Bupivicaine (.040x528) x125% +60 = $103.12.

Underpaid by $34.22…"

Amount in Dispute: $34.22

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Provider's Request for Medical Fee Dispute Resolution involves…The Provider submits no documentation to substantiate the use of the $60.00 compounding fee…Carrier contends the Provider has been properly reimbursed for the morphine solution at issue. "

Response Submitted by: William E. Weldon, Travelers

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 15, 2017	J7999-KD	$34.22	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the fee guideline HCPCS Level II codes A, E, J, K, and L.
3. 28 Texas Administrative Code §134.1(f) sets out the requirements for a fair and reasonable reimbursement amount in the absence of a contract or a fee guideline.

4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P12 – Workers' Compensation Jurisdictional fee schedule adjustment.
   - 45 – Charges exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.
   - 252 – The recommended allowance is based on the value for services performed by a licensed non-physician practitioner.
   - 309 – The charge for this procedure exceeds the fee schedule allowance. Drug payment is based on pharmacy reimbursement guidelines.
   - W3 – Additional payment made on appeal/reconsideration.
   - 947 – Upheld. No additional allowance has been recommended.

Issues & Findings

The health care provider, Consultants in Pain Medicine PA, contends that the total payment for the service in dispute should be $103.12. The carrier, Traveler's Indemnity Co, paid $68.90. Although each party asserts substantially similar reimbursement methodologies, the resulting reimbursement calculation differs on one of the payment factors. In the following paragraphs, the Division first weighs the evidence brought by the requestor to establish whether its' asserted methodology meets the requirements of the applicable Division Rules.

1. What is the applicable fee guideline?

The service in dispute was billed under code J7999-KD. Review of the 2017 American Medical Association (AMA), Healthcare Common Procedure Coding System (HCPCS) finds that J7999 is described as a Compounded drug, not otherwise classified. According to the requestor, the service provided is a re-fill of an implanted pain pump.

Rule 28 Texas Administrative Code §134.203 (d) sets out the fee guideline for Healthcare Common Procedure Coding System (HCPCS) Level II code J. Paragraph J states:

> (d) The MAR for Healthcare Common Procedure Coding System (HCPCS) Level II codes A, E, J, K, and L shall be determined as follows:
>
> (1) 125 percent of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule;
>
> (2) if the code has no published Medicare rate, 125 percent of the published Texas Medicaid fee schedule, durable medical equipment (DME)/medical supplies, for HCPCS; or
>
> (3) if neither paragraph (1) nor (2) of this subsection apply, then as calculated according to subsection (f) of this section.

J7999-KD is not listed in the Medicare DMEPOS fee schedule, nor does J7999-KD have a published Texas Medicaid rate. For those reasons, §134.203 (d)(3) points to (f) which states that reimbursement shall be provided in accordance with §134.1.

The Division concludes that reimbursement for J7999 shall be made in accordance with the Division's general fair and reasonable guidelines found at 28 Texas Administrative Code §134.1(f).

2. Did the requestor provide documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1(f) of this title?

Although the requestor provided a detailed calculation of its proposed fair and reasonable amount for J7999, it failed to articulate the reasons why the additional amount it sought was fair and reasonable when compared to the reimbursement it had already received before filing this medical fee dispute.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

		December 7, 2017
Signature	Medical Fee Dispute Resolution Director	Date

RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.